

**Confidential Patient Information**

**Date:** \_\_\_\_\_

Patient Name _____			Last _____		First _____		Middle _____	
Birthdate (DD/MM/YY) _____			Age _____		Gender Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Street Address _____							Apartment _____	
City _____			Province _____		Postal Code _____			
Home Phone _____			Work Phone _____		Mobile _____			
Email Address _____								
Occupation _____				Employer _____				
Emergency Contact (Name, Relationship, Phone) _____								
Medical Doctor _____			Phone _____		Last Physical _____			
Your main reason for consulting us? _____								
Who may we thank for your referral? _____								

**Release of Liability and Privacy Policy:**

I have been informed, understand, and acknowledge that sports and fitness, health and wellness treatments, physical rehabilitation, personal training, weight training and aerobic exercises, including the use of equipment, are potentially hazardous activities. I agree to consult my medical doctor for any past or current medical conditions, prior to starting any physical activity or exercise program(s). I also have been informed, understand, and acknowledge that such health and fitness treatments and activities involve a risk of injury, including a remote risk serious injury, disability, or death, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the risks and danger involved. I hereby agree to expressly assume and accept any and all risk of injury or death that I may suffer and hereby irrevocably release Lawrence Park Health and Wellness Clinic Inc., its owner, director, agents, officers, contractors, staff and employees from any liability with respect to these risks while participating in a health and wellness program / chiropractic / physiotherapy / acupuncture / registered massage therapy / athletic therapy / nutritional counseling / personal training / physical rehabilitation program and any exercise / physical activity. I have fully read, understood and completed this form. Any questions were answered to my full satisfaction. I have read the above liability release and accept these policies as they related to chiropractic / physiotherapy / acupuncture treatment programs, registered massage therapy, athletic therapy, nutritional counseling, personal training and all other therapy and exercise services with Lawrence Park Health and Wellness Clinic Inc., its owner, director, agents, officers, contractors, staff and employees.

I understand that in order to provide me with comprehensive integrative health care, Lawrence Park Health and Wellness Clinic Inc. will collect personal and medical information about me. **I authorize Lawrence Park Health and Wellness Clinic Inc. to obtain / share / release medical information pertaining to myself to / from my family physician and other Lawrence Park Health and Wellness Clinic Inc. practitioners as required for my course of care.** I understand that I can rescind this consent at any time by doing so in writing. I have had the opportunity to review Lawrence Park Health and Wellness Clinic's Privacy Policy and have been provided the opportunity to ask any questions I have about the Privacy Policy and, if applicable, they have been answered to my satisfaction.

I understand and agree that extended health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of each visit. I understand and accept that **I am responsible for the full fee for any treatments / sessions not cancelled 24 hours in advance**, and if I suspend or terminate my care and treatment, or fail to provide any fees for professional services rendered to me, they will be immediately due and payable and will be charged to my credit card on file if payment is not received within five (5) business days.

Patient / Client Name: \_\_\_\_\_

Patient / Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_